

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07479

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07471

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			ESTIMATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR			
William Henry Baptist						2a. DATE KNOWN OF DEATH			ESTIMATED <input checked="" type="checkbox"/> May 9 1969			2b. HOUR 20 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
MALE		Negro		2/2/62		67 YRS.		MONTHS		DAYS		Month Day Year		M	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.			
Md			USA						Talbot						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton			Memorial			Labors									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER			
Md			Talbot			Easton						Route #4 Box 178			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
William Baptist			Hannie Deshields												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			218-10-5407			Marie A. Baptist									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Carcinoma prostate															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
(b) metastases															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER				5-14-69							
WELTY				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				5/13/69				Unionville Cem				Easton Talbot Md			
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George H. Deshields Easton Md								DATE MAY 16 1969		Charles Judge					

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818-10-2401 501516 H. Gokhale

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James M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
07480					07472				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last					Month Day Year				
REBA S BENNINGTON					5 69 11 P M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		11/9/91		78 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
MD		USA				TALBOT		EASTON	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN	
MEMORIAL		DR HOME				MD		CAROLINE RIDGELEY	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER		14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
				OLIVER CLARK		SALLIE DULIN		NO	
16b. SOCIAL SECURITY NO.		17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		DOUGLAS BENNINGTON, GREENSBORO.		PART 1. DEATH WAS CAUSED BY:		12 hrs.			
				IMMEDIATE CAUSE (a) 4109					
				DUE TO, OR AS A CONSEQUENCE OF					
				(b)					
				DUE TO, OR AS A CONSEQUENCE OF					
				(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>then</u> , 19 <u>64</u> , to <u>1 May</u> , 19 <u>69</u> , that (I) <u>last</u> saw the deceased alive on <u>1 May</u> , 19 <u>69</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.		22b. SIGNATURE <u>Memor Harrison MD</u>		22c. DATE SIGNED <u>1 May 69</u>					
22d. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>		22e. ADDRESS <u>Easton Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>MAY 15, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIDGELEY</u>		23d. LOCATION (City or Town) (County) (State) <u>RIDGELEY CAR MD</u>			
24. FUNERAL DIRECTOR <u>CHARLES V. MOORE</u>		ADDRESS <u>DEBTON</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

OFFICE OF THE DIRECTOR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Talbot County Medical Examiner, Dr. Robert W. Trever, contacted per phone 5-22-69. Stated NOT medical examiner case.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M
Jennie Couch					Bloomfield	May 21 1969			9:20
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		8-8-80		88 YRS.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
New Jersey			U. S. A.				TALBOT Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
EASTON			HOUSE IN THE PINES			Housekeeper			HOUSEKEEPER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
New Jersey			New Jersey		Plainfield		* *		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Samuel Julius Couch			Laura Mulford.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			216-48-5021		Howard V.L. Bloomfield. Oxford Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic brain syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fracture left femur. Severe anemia, cause not determined</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 4 9 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell while on unauthorized walk</u>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>County road</u>		21f. LOCATION. Street or R.F.D. No. City or Town County State <u>Mrs. Orville Bryan Trappe Talbot Md.</u> <u>Custodial Care Home</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-9</u> , 19 <u>69</u> , to <u>5-21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert W. Trever M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5-22-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>					22e. ADDRESS <u>RD 3 Easton Md. 21601</u>				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <u>May 22, 69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Edwards Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington DC</u>			
24. FUNERAL DIRECTOR <u>Robert W. Trever</u>					25a. REC'D BY REGISTRAR <u>MAY 23 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Orville Bryan</u>		

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UNITED STATES OF AMERICA

John A. Gorton

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1916-1917

John A. Gorton, U.S.A.

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07482		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07474		
CERTIFICATE OF DEATH								
1. DECEASED-NAME (Type or print) M. FLORENCE			First Middle Last B UCK			2a. DATE OF DEATH 5 Month 6 Day 69 Year 6:15A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 4-25-92		6. AGE (in years) 75 YRS.		
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT		
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Harry James Rich		15. MOTHER'S MAIDEN NAME First Middle Last Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 218 34 7873		17. INFORMANT Address LeCompte Funeral Service records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 4-21 , 19 69 , to 5-6 , 19 69 , that (I) (we) last saw the deceased alive on 4-23 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Stephen O. Canale				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-6-69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 8, 1969		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland		
24. FUNERAL DIRECTOR ANTHONY P. LeCOMPTE, CAMBRIDGE, MD				ADDRESS CAMBRIDGE, MD		25a. REC'D BY REGISTRAR MAY 8 1969		
						25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07483		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07475	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
Charles		C.	Burnette		5 Month 24 Day 69 Year		9:00M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
male		white		3-23-01		68 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Va.		U. S. A.				Talbot Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		House In The Pines		Ret. Millwright		Machine Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.		Dorchester		Cambridge		13e. STREET AND NUMBER	
						Rt. # 3 Green Cove	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		
Cornelius D. Burnette					Emma L. Leftwich		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		None		Ruth E. Burnette (Wife) Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> <u>1621</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING (If contributing, notify medical examiner) <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>5 Dec 1967</u> to <u>24 May 1969</u> , that (I) (we) last saw the deceased alive on <u>21 May 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
<u>Stephen P. Lang</u>		<u>5-24-69</u>		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		5/26/69		Cedar Hill Cemetery		Suitland Pr. Geo. Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
LeCompte FUNERAL SER. CAMBRIDGE, MD.				MAY 26 1969		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Thomas Henry Callahan 3rd</i>			First Middle Last		2a. DATE OF DEATH Month Day Year <i>MAY 18 1969</i>			2b. HOUR 7:00 PM		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-24-25</i>			6. AGE (In years last birthday) <i>44</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.				
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>MECHANIC</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>GARAGE + SERVICE STATION</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <i>MARYLAND</i>			13b. COUNTY <i>QUEEN ANNES CENTREVILLE</i>		13c. CITY OR TOWN <i>Centreville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Kidwell Ave.</i>	
14. FATHER'S NAME First Middle Last <i>Thomas Henry Callahan JR</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>MARTHA CRAWFORD GREENEWALT</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>217-30-8808</i>		17. INFORMANT <i>wife</i> Address <i>MRS. MARY F. CALLAHAN CENTREVILLE, MD.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>malignant fibrous xanthoma</i> <i>2720</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>18 May, 1969</i> , to <i>18 May, 1969</i> , that (I) (we) lost saw the deceased alive on <i>18 May, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Stephen P. Carney</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5-19-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>					22e. ADDRESS <i>Easton, Maryland 21601</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>May 20, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chesterfield Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Centreville, Q.A. Co., Md.</i>			
24. FUNERAL DIRECTOR <i>John H. Baulch, Barton Bros., Centreville, Md.</i>					25a. RECD BY REGISTRAR DATE <i>MAY 22 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07485										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH										07477														
1. DECEASED-NAME (Type or print) SARAH First M. Middle CARROLL Last					2a. DATE OF DEATH 5 Month 15 Day Year 69					2b. HOUR 1 A M														
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 6/21/1913			6. AGE (In years last birthday) 55 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH TALBOT Md.															
10. CITY OR TOWN OF DEATH Easton					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) ASST CASHIER					12b. KIND OF BUSINESS OR INDUSTRY BANK									
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD					13b. COUNTY TALBOT					13c. CITY OR TOWN EASTON					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 506 S. AURORA ST				
14. FATHER'S NAME First WILBUR H. Middle MORRIS Last					15. MOTHER'S MAIDEN NAME First MARGARET Middle HENDRICKSON Last																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No					16b. SOCIAL SECURITY NO. 218-24-4485					17. INFORMANT Address W. O. J. CARROLL, EASTON, MD.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 174X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Breast DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 yrs									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from Apr. 5/14 , 19 69 , to 5/15 , 19 69 , that (I) (we) last saw the deceased alive on 5/14 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE S. Kreck DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 5/16/69														
22d. PHYSICIAN'S NAME (Type) S. Kreck, Jr										22e. ADDRESS EASTON, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					23b. DATE 5/18/1969					23c. NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY					23d. LOCATION (City or Town) (County) (State) EASTON MD									
24. FUNERAL DIRECTOR Maurice A. Newman										25a. REC'D BY REGISTRAR Easton, Md					25b. REGISTRAR'S SIGNATURE Charles Judge									
DATE MAY 21 1969																								

TO THE SECRETARY OF THE ARMY
FROM THE SECRETARY OF THE ARMY

Subject: [illegible]

Reference is made to [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07486		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07478	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>Peter France Chandon</i>			2a. DATE OF DEATH 5 Month 30 Day 1969		2b. HOUR M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1/6/1904</i>		6. AGE (In years lost birthday) <i>65</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>France</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.	
10. CITY OR TOWN OF DEATH <i>Easton (rural)</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Green Marsh</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Architect</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Talbot</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <i>John Arthur Chandon</i>		15. MOTHER'S MAIDEN NAME <i>Mary Albert</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>230-46-9005</i>		17. INFORMANT <i>Dr. C.R.W. Bain, Easton, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>50 DAYS</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Emphysema</i>							
19a. DATE OF OPERATION <i>NONE</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>December 1969</i> to <i>MAY 29th 1969</i> , that (I) (we) last saw the deceased alive on <i>MAY 29th 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Carlton RD</i>		DEGREE <i>CRW BAIN</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/30/69</i>	
22d. PHYSICIAN'S NAME (Type) <i>CRW BAIN</i>		22e. ADDRESS <i>210 DOVER, EASTON, Md.</i>					
23a. BURIAL, CREMATION, or other disposition <i>Burial</i>		23b. DATE <i>6/3/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JUN 3 1969</i>		25b. REGISTRAR'S SIGNATURE <i>McDonald, Ind...</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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|---|--|--|------------------------------------|---|---|
| 07487 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07479 | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH |
| Sarah B Cooper | | | | | Month Day Year 5 23 1969 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | 6. AGE (In years last birthday) |
| Female | | Negro | | May 10, 1910 | 59 YRS. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 9. COUNTY OF DEATH | |
| Maryland | | USA | | Talbot | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| Easton | | Memorial Hospital | | Domestic | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. STREET AND NUMBER |
| Maryland | | Talbot | | Oxford | Anderson Farm |
| 14. FATHER'S NAME | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME |
| George | | | | | Arella Gibson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 219 14 4311 | | Raymond Cooper Oxford, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4380 Cerebrovascular Accident | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cerebrovascular Disease | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/25, 1969, to 5/25, 1969, that (I) (we) last saw the deceased alive on 5/25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |
| Robert M. McDonald | | | | 22c. DATE SIGNED 5/25/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Robert M. McDonald | | Easton, Maryland 21601 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | 5/29/69 | Screamersville | | Near Oxford Talbot Md. |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Dashfield Funeral Home | | MAY 29 1969 | | William V. ... | |

03483

CENTRAL OF DEATH



Form with multiple sections and fields, mostly containing faint, illegible text. The form appears to be a standard document with various headings and sub-sections, but the specific content is not readable due to the quality of the scan. The form is oriented vertically and occupies the majority of the page.

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|--|---|--|
| 07488 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07480 | |
| 1. DECEASED-NAME (Type or print) <i>First Middle Lost</i>
<i>Louis Irvin Copper</i> | | | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>25</i> Year <i>1969</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Negro</i> | | 5. DATE OF BIRTH
<i>February 2, '11</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Laborer</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Easton</i> | |
| 14. FATHER'S NAME
<i>Walter</i> | | 15. MOTHER'S MAIDEN NAME
<i>Stella</i> | | 16. SOCIAL SECURITY NO.
<i>217 09 1344</i> | |
| 17. INFORMANT
<i>Charles Copper</i> | | 18. ADDRESS
<i>RFD#3, Easton Point</i> | | 19. DATE OF OPERATION | |
| 20. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 21. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 23. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 24. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 25. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 26. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 27. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<i>5/20</i> | | 28. LOCATION Street or R.F.D. No. City or Town County State
<i>5/25</i> <i>19 69</i> <i>5/25</i> <i>19 69</i> | |
| 29. I certify that (I) (this hospital) attended the deceased from <i>5/25</i> <i>19 69</i> , to <i>5/25</i> <i>19 69</i> , that (I) (we) last saw the deceased alive on <i>5/25</i> <i>19 69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 30. SIGNATURE
<i>S. KRECH, JR.</i> | | 31. DATE SIGNED
<i>5/26/69</i> | |
| 32. PHYSICIAN'S NAME (Type)
<i>S. KRECH, JR.</i> | | 33. ADDRESS
<i>EASTON, Md.</i> | | 34. REC'D BY REGISTRAR
<i>Charles Yarger</i> | |
| 35. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 36. DATE
<i>5/30/69</i> | | 37. NAME OF CEMETERY OR CREMATORY
<i>Newtown</i> | |
| 38. FUNERAL DIRECTOR
<i>G. B. Nash</i> | | 39. ADDRESS
<i>426 Dover Ave. Easton</i> | | 40. REGISTRAR'S SIGNATURE
<i>Charles Yarger</i> | |

02483

(M)

Handwritten notes on lined paper, including the phrase "Constitution of the" and other illegible text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|---|---|---|---|---|--|---|--|
| 07489 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07481 | | | |
| Item 4 Film 413 5/29/69 kk | | | | | | CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME
(Type or print) <i>William</i> | | | First <i>William</i> Middle <i>Corbin</i> Last <i>Cummings</i> | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>21</i> Year <i>1969</i> | | 2b. HOUR <i>12:00</i> M | |
| 3. SEX
<i>MALE</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>9/18/97</i> | | 6. AGE (In years last birthday)
<i>71</i> YRS. | | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Talbot</i> | | Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>BANKING (RETIRED)</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>TRUST DEPT</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i> | | 13b. COUNTY
<i>TALBOT</i> | | 13c. CITY OR TOWN
<i>RE. EASTON</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
First <i>Charles</i> Middle <i>Marion</i> Last <i>Cummings</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Elizabeth</i> Middle <i>Vones</i> Last <i></i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>216-03-8689</i> | | 17. INFORMANT
<i>MRS W M C. Cummings</i> | | Address
<i>EASTON MD</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Artery Heart Failure</i>
<i>4123</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Chronic Culture Heart Dis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Arteriosclerotic Cardiovascular Disease</i>
<i>yes</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 yrs.</i>
<i>15 yrs.</i>
<i>yes</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-21-1969</i> , 19 <i>69</i> , to <i>5-21</i> , 19 <i>69</i> , that (I) (we) saw the deceased alive on <i>5-21-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>R. Lane Wroth, MD</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-22-69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>R. Lane Wroth</i> | | M.D. | | 22e. ADDRESS
<i>St. Michaels, Md.</i> | | 5/22/69 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>May 23, 69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>DRUID RIDGE</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>PRESVILLE TALBOT MD</i> | | | |
| 24. FUNERAL DIRECTOR
<i>R. Lane Wroth</i> | | ADDRESS
<i>Easton Md</i> | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 23 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>R. Charles Judge</i> | | | |

02378



COPIED

1943

1943

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1943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07490

07482

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|--|---------|---|--------|---|---|---|-------------------------------|---|--------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | Day | Year | 2b. HOUR |
| Grace Cleveland Davis | | | | | 42 | | 7 | 0 | 69 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
| Female | White | 5/21/1886 | | 82 YRS. | | | | | Month | Day |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Md. | | USA | | | | Talbot | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Cordova (rural) | | RFD | | Housework | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | Talbot | | Easton | | | | Goldsboro Street | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| George M. Thomas | | | | | Elizabeth E. Conkran | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | |
| no | | | | 220-46-51797 | | Wendell Davis, Easton, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Accidental Drowning:</u>
9109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Senility</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 11:41 19 69 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Drowning | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Near home | | 21f. LOCATION Street or R.F.D. No.
R.F.D. | | City or Town
Cordova | | County
Talbot | | State
Md. |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Howard F. Kinnamon</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) Howard F. Kinnamon M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | May 6, 1969 | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, or other disposal | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | | 5/5/1969 | | Spring Hill | | Easton, Md. | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | |
| MAURICE E. NEWMAN & SON, Easton, Md. | | | | | | | | DATE MAY 8 1969 | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | |
| | | | | | | | | | | |

NAME (Last, first, middle)

DATE OF BIRTH

SEX

EDUCATION

RELIGION

INDUSTRY

RESIDENCE

MAY 6, 1909

X

HOWARD E. KINSMAN M.D.

REMARKS

REMARKS

REMARKS

REMARKS

MAY 8, 1909

REMARKS

REMARKS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07483

07491

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | |
|---|-------------------------|---|---|--------------------------------|--|---|--|--|
| 1. DECEASED-NAME
(Type or Print)
<i>Henry Gladstone Edwards</i> | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 5 26 1969 | | | 2b. HOUR
12:20 P.M. | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
28 Aug. 1898 | 6. AGE (In years last birthday)
70 YRS. 8 MONTHS 28 DAYS | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month May Day 26 Year 19 69 |
| 7a. BIRTHPLACE (State or foreign country)
Northumberland Co. U S A | | | 7b. CITIZEN OF WHAT COUNTRY?
U S A | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. COUNTY OF DEATH
Talbot | | | 10. CITY OR TOWN OF DEATH
Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give "street" address)
D.O.A. Memorial Hospital | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Vice-Pres. Paper Manf Co. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death)
Maryland Wicomico Salisbury | | |
| 13b. CITY OR TOWN
Salisbury | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER
1212 Camden Ave. | | |
| 14. FATHER'S NAME
Dr. William Henry Edwards | | | 15. MOTHER'S MAIDEN NAME
Elizabeth Cockrell | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes W.W.# 1 | | |
| 16b. SOCIAL SECURITY NO.
217-10-3566 | | | 17. INFORMANT
Mrs. Elizabeth T. Edwards (Wife) | | | 17b. ADDRESS
1212 Camden Ave. Salisbury, Md. 21801 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Cardiac hypertrophy
DUE TO, OR AS A CONSEQUENCE OF
(b) 2nd coronary occlusion due to
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
<i>E. C. H. Schmidt, M.D.</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
27 May 69 | | |
| EXAMINER'S NAME (Type)
E. C. H. Schmidt, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| ADDRESS (Street, city, town, or county) | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
May 28/1969 | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parsons Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Salisbury, Maryland | | | 24. FUNERAL DIRECTOR
HOLLOWAY & COMPANY SALISBURY, MARYLAND | | |
| ADDRESS
SALISBURY, MARYLAND | | | 25a. REC'D BY REGISTRAR
DATE MAY 28 1969 | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

10548

RECEIVED
MAY 28 1959
U.S. DEPARTMENT OF HEALTH
BUREAU OF VETERANS AFFAIRS
WASHINGTON, D.C.

Male White 28 Aug. 1896 70 8 38

Washington, D.C. U.S.A.

Dr. William Henry Edwards

Wisconsin

Elizabeth Cookman

10548-10548 (M) 10548-10548 (M) 10548-10548 (M)

Elizabeth Cookman

10548-10548 (M) 10548-10548 (M) 10548-10548 (M)

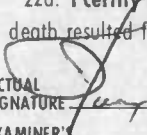

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07492

07484

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|-------------------------|---|---|---|---|---|--|
| 1. DECEASED-NAME (Type or Print)
First Middle Last
Mary Elsie Edwards | | | 2a. DATE KNOWN OF DEATH
Month Day Year
5 10 1969 | | | 2b. HOUR
2A M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
7-15-1891 | 6. AGE (In years last birthday)
77 YRS | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year
5 10 1969 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Talbot | |
| 10. CITY OR TOWN OF DEATH
Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
House in the Pines | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Caroline | 13c. CITY OR TOWN
Greensboro | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
Sunset Ave. | |
| 14. FATHER'S NAME First Middle Last
John Harvey Coursey | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mable Laura Williams | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
220-03-5087B | | 17. INFORMANT ADDRESS
Alvin Edwards Greensboro, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senility, Chronic Brain Syndrome
DUE TO, OR AS A CONSEQUENCE OF
(b) Parlinsomism Arteriosclerotic
DUE TO, OR AS A CONSEQUENCE OF
(c) generalized Arteriosclerosis | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10yrs |
| | | | | | | | 15 yrs |
| | | | | | | | 20yrs |
| | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Fracture of the right femoral neck non reduced because of age |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 10:30
P.M. 31/69 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fell in her home | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Greensboro Maryland Caroline | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
 | | EXAMINER'S NAME (Type)
Harold B. Plummer M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
3/14/69 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
5-13-69 | | 23c. NAME OF CEMETERY OR CREMATORY
Greensboro | | 23d. LOCATION (City or Town) (County) (State)
Greensboro, Caroline, Md | |
| 24. FUNERAL DIRECTOR
J. E. Boulais Greensboro, Md. | | | | 25a. REC'D BY REGISTRAR
MAY 16 1969 | | 25b. REGISTRAR'S SIGNATURE
 | |

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4109

1

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|---|---|--|---|------------------------|---|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | |
| ROBERT HELMAR ESTERSON, Sr. | | | | | | May 18, 1969 | | | 8:00 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | | |
| Male | | White | | March 26, 1897 | | 72 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Minnesota | | USA | | | | Talbot County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| St. Michaels | | | ----- | | | V.P. Stapling Machines | | Safe Packaging | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Talbot | | St. Michaels | | | | 118 E. Chestnut St., | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Olaf Ole Esterson | | | | | | Ingrid Svaard | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| Yes | | | WW I | | 161-03-3300 Mrs. Robert H. Esterson, St. Michaels, M.D. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) myocardial infarction | | | | | | | | | | | |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) atherosclerotic coronary artery | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| chronic cardiac failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 5-18-1969, that (I) (we) last saw the deceased alive on 4-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| GUY M. REESBR, Jr., M. D. | | | | | | | | | | 5-19-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| | | Burial | | May 20, 1969 | | Olivet Cemetery | | St. Michaels, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| James E. Leonard, St. Michaels | | | | | | MAY 23 1969 | | [Signature] | | | |

072400

STATEMENT OF DEATH

MAY 12, 1967

ESTABLISHED, ST.

DEATH

78

MAY 12, 1967

WHITE

MALE

WATSON COUNTY

USA

WATSON COUNTY

WATSON COUNTY

WATSON COUNTY

THE W. WATSON CO.

WATSON COUNTY

WATSON COUNTY

WATSON COUNTY

WATSON COUNTY

WATSON COUNTY

WATSON COUNTY, ST. WATSON COUNTY, ST. WATSON COUNTY, ST.

WATSON COUNTY

WATSON COUNTY, ST. WATSON COUNTY, ST. WATSON COUNTY, ST.

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WATSON COUNTY, ST. WATSON COUNTY, ST. WATSON COUNTY, ST.

WATSON COUNTY, ST. WATSON COUNTY, ST. WATSON COUNTY, ST.

WATSON COUNTY, ST. WATSON COUNTY, ST. WATSON COUNTY, ST.

4109
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07494

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07486

| | | | | | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|-----------------------------------|--|--|--------------------------|--|---|--|
| 1. DECEASED-NAME
(Type or print) William Flamer | | | 2a. DATE OF DEATH
Month May Day 12 Year 1969 | | | 2b. HOUR
1:35 PM | | | | | | | | | |
| 3. SEX
F | | 4. RACE
N | | 5. DATE OF BIRTH
JAN. 21, 1933 | | 6. AGE (In years last birthday)
36 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
TALBOT Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
RODGELY | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
EASTON | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
MD | | | 13b. COUNTY
CHARLOTTE | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | |
| 14. FATHER'S NAME
First VICTOR Middle FLAMER Last FLAMER | | | 15. MOTHER'S MAIDEN NAME
First LILLY Middle HINES Last HINES | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address MRS. W.M. F. FLAMER, RODGELY, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Congestive Cardiac Failure
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 5 , 19 69 , to May 12 , 19 69 , that (I) (we) last saw the deceased alive on May 12 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Charles H. Stonestifer DEGREE
22d. PHYSICIAN'S NAME (Type) Charles H. Stonestifer, M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
May 15, 1969 | | | | | | | |
| 22e. ADDRESS
Greensboro, Md. 21639 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
May 17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
SAND TOWN | | 23d. LOCATION (City or Town) (County) (State)
HILLSBORO CAR. MD. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
CHARLES V. MOORE | | | | ADDRESS
DENTON MD. | | 25a. REC'D BY REGISTRAR
MAY 21 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

02494

REPUBLIC OF CHINA

OFFICE OF THE COMMISSIONER OF THE CUSTOMS

Import

Export

Transit

12-10-55

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12-10-55

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12-10-55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|----------------------------|--|
| 07495 | | | | | 07487 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| First Sophie Middle J. Last Gibson | | | | | Month May Day 1 Year 1969 | | | 6A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Female | | Negro | | August 2, 1885 | | 83 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | | USA | | | | Talbot Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Wye Heights | | RFD 2, Longwoods | | Laborer | | None | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Talbot | | | | | | RFD 2, Longwoods | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Richard Blackwell | | | Fannie Johnson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 220 01 1804 | | Daisy Gibson, Post Office, Wye Mills | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Obstructive pneumonia, unknown cause</u> | | | | | | | | 6 weeks | | |
| 5760 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-18</u> , 19 <u>69</u> , to <u>4-24</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Stephen P Carney</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>5-7-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. Stephen P Carney</u> | | | | | 22e. ADDRESS <u>P.O. Box 929 632 Elizabeth Street, Easton, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 5/5/69 | | Richards | | Easton Talbot Maryland | | | | |
| 24. FUNERAL DIRECTOR <u>Barbara L. Dashiell</u> | | | | | ADDRESS <u>426 Dover Easton, Md. 21601</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | | | | | |

STATE OF DEPT. OF STATE

12/10/50



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 07496 | | | | | | | | | |
| 07488 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Victor P Gillespie</i> | | | | | 2a. DATE OF DEATH <i>5</i> Month <i>2</i> Day <i>69</i> Year | | | 2b. HOUR <i>7 A.</i> M. | |
| 3. SEX <i>Male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>June 28, 1905</i> | | 6. AGE (In years lost birthday) <i>63</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Q. A. Co. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>TALBOT</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Owner - Concrete Plant</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Queen Anne</i> | | 13c. CITY OR TOWN <i>Sudlersville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First <i>G. Edward</i> Middle <i>Gillespie</i> Last | | | | 15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>S</i> Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> | | 16b. SOCIAL SECURITY NO. <i>WW 11 213 01 8954</i> | | 17. INFORMANT <i>Mrs. Juliet S. Gillespie</i> | | Address <i>Sudlersville, Maryland</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
<i>4339</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Dyspneophrenia - left.</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>14 Apr</i> , 19 <i>69</i> , to <i>2 May</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>1 May</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Thurston Harrison M.D.</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>2 May 69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i> | | | | 22e. ADDRESS <i>Chestertown, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>5/5/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Sudlersville Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Sudlersville, Md.</i> | | | |
| 24. FUNERAL DIRECTOR <i>St. Will's Wells</i> | | ADDRESS <i>Chestertown, Md.</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | 25b. REGISTERED SIGNATURE <i>Charles Judge</i> | | DATE <i>MAY 5 1969</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 45M - 1/69

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07497 CERTIFICATE OF DEATH 07489 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <u>Mary</u> <u>Lewis</u> <u>Handley</u> | | | 2a. DATE OF DEATH
Month <u>May</u> Day <u>21</u> Year <u>1969</u> | | | 2b. HOUR-
<u>10:45</u> M | | | |
| 3. SEX
<u>FEMALE</u> | | 4. RACE
<u>WHITE</u> | | 5. DATE OF BIRTH
<u>4-25-96</u> | | 6. AGE (In years last birthday)
<u>73</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN <u> </u> | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>TALBOT</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<u>EASTON</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>HOUSE IN THE PINES</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>WIFE</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>HOME</u> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
<u>Maryland</u> <u>STATE</u> | | | 13b. CITY OR TOWN
<u>QUEEN ANNES CENTREVILLE</u> | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>PIONEER POINT</u> | | |
| 14. FATHER'S NAME
<u>Summerfield</u> <u>Lewis</u> | | | 15. MOTHER'S MAIDEN NAME
<u>IDA</u> <u>MAE</u> <u>Mills</u> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <u>No</u> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<u>218-300-9728</u> | | 17. INFORMANT <u>Husband</u>
<u>Joseph S. Handley, CENTREVILLE, Md.</u> Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary of the heart</u>
<u>180X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u> </u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u> </u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>25 months</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-16</u> , 19 <u>69</u> to <u>5-21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Stephen P. Carney</u> | | | | DEGREE
ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>5-22-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>STEPHEN P. CARNEY</u> | | | | 22e. ADDRESS
<u>DUTCHMANS BANK, EASTON, MD.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<u>MAY 24, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dorchester Memorial Park</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Cambridge, Dorchester Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>James B. Burt Jr. Burt Bros, Centerville, Md.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 28 1969</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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RESEARCH OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07498

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07490

| | | | | | | | | | |
|--|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
<i>Edra D. HARRISON</i> | | | 2a. DATE OF DEATH
Month Day Year
<i>3 23 1969</i> | | | 2b. HOUR
<i>9¹⁵ PM</i> | | | |
| 3. SEX
<i>female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>May 27, 1888</i> | | 6. AGE (In years last birthday)
<i>80</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Trappe, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Ta/60t</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>none</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Oxford</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last
<i>Henry Diefenderfer</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Janie Dolby</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>no</i> | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>220-01-0624</i> | | 17. INFORMANT Address
<i>Wm. Harrison Vienna, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Disruptive Carina</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Disruptive Mellitus</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
2500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days, 10 yr.</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Acute Pyelonephritis</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) the deceased attended the deceased from <i>May 1967</i> , to <i>5/23 1969</i> , that (I) the deceased last saw the deceased alive on <i>5/23 1969</i> , and that in my <i>my</i> opinion death occurred on the date and hour and from the causes stated above, (I) did <i>did</i> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert M. McDonald</i> | | | | DEGREE
<i>M.D.</i> | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Robert M. McDonald M.D.</i> | | | | 22e. ADDRESS
<i>Easton, Maryland 21601</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>5/26/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Springhill Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Easton, Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Harold Williams - Federburg, Md.</i> | | | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 29 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

20356

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|---|--|--|---|------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Jennie B. Helsby | | | | | 2a. DATE OF DEATH
Month 5 Day 12 Year 1969 | | | 2b. HOUR
5:15 P.M. | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
3/26/1885 | | | 6. AGE (In years last birthday)
84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
3 6 | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Talbot | | | | |
| 10. CITY OR TOWN OF DEATH
Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ministers wife | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY
Talbot | | 13c. CITY OR TOWN
Trappe | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3 Powell Ave. | |
| 14. FATHER'S NAME First Middle Last
William Thomas Davis | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Eliza Harrison | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
no | | 16b. SOCIAL SECURITY NO.
217-28-4032-D | | 17. INFORMANT Address
George Philip Helsby, Berwyn, Penna. 19312 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Leukemia
2070 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-26-1969 , to 5-12-1969 , that (I) (we) last saw the deceased alive on 5-12-69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Dorsett D. Smith | | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/12/69 | |
| 22d. PHYSICIAN'S NAME (Type)
DORSETT D. SMITH | | | | | 22e. ADDRESS
EASTON, MD. 21601 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
5/15/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill | | | 23d. LOCATION (City or Town) (County) (State)
Easton, Talbot, Maryland | | | |
| 24. FUNERAL DIRECTOR
Jay D. H... .. | | | | | ADDRESS
Easton, Md. | | 25a. REC'D BY REGISTRAR
DATE MAY 14 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

87699

CLERK OF THE COURT

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VR A16 (4)
45M - 786

24. FUNERAL DIRECTOR
Tramo

07500

George A. ...
... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07501

07493

| | | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|----------------------------------|--|
| 1. DECEASED-NAME (Type or print) <i>Charles Emory Horney</i> | | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>25</i> Year <i>1969</i> | | | 2b. HOUR <i>6:30</i> PM | | | | |
| 3. SEX <i>MALE</i> | | 4. RACE <i>WHITE</i> | | 5. DATE OF BIRTH
<i>JUNE-1916</i> | | 6. AGE (In years lost birthday) <i>52</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i>5</i> DAYS <i>10</i> HOURS <i>15</i> MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Talbot</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>University of Maryland</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>CORRECTION CAMP</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>STATE</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i> | | | 13b. COUNTY <i>S.A.</i> | | 13c. CITY OR TOWN <i>CHESTER</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>xx</i> | |
| 14. FATHER'S NAME First <i>HARRY W.</i> Middle <i>H.</i> Last <i>HORNEY</i> | | | 15. MOTHER'S MAIDEN NAME First <i>MAMIE</i> Middle <i>P.</i> Last <i>PIERSON</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (or unknown) <i>Yes</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. <i>217-16-7144</i> | | 17. INFORMANT <i>MRS. REBA HORNEY - CHESTER, MD.</i> | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pleural carcinomatosis</i>
<i>1991</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Metastatic carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Primary site unknown</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Dec., 1967</i>
<i>Dec., 1967</i>
<i>Uncertain</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Robert W. Trever</i> M.D. DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>5-26-69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i> M.D. | | | | | 22e. ADDRESS <i>Easton, Maryland 21601</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>MAY 28</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>STEVENSVILLE</i> | | 23d. LOCATION (City or Town) (County) (State) <i>STEVENSVILLE MD.</i> | | | | |
| 24. FUNERAL DIRECTOR <i>Lane Funeral Home Church Hill Md.</i> | | | | | 25a. REC'D BY REGISTRAR <i>JUN 3 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

50250

1005

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

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|--|--|---|----------------------|---|--------------------|---|--|--|
| 07502 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07494 | | |
| CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <u>Stephen</u> | | | First <u>STEPHEN</u> | Middle <u>HRYNKO</u> | Last <u>Hrynko</u> | 2a. DATE OF DEATH
Month <u>5</u> Day <u>7</u> Year <u>69</u> | | 2b. HOUR
<u>11</u> M |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Jan. 4, 1875 | | 6. AGE (In years
lost birthday)
94 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country) <u>Austria</u> | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Talbot</u> Md. | | |
| 10. CITY OR TOWN OF DEATH
<u>Easton</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) <u>Memorial</u> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<u>Retired Farmer</u> | | 12b. KIND OF BUSINESS OR
INDUSTRY
<u>Farm</u> | | |
| 13a. USUAL RESIDENCE (Where deceased
lived, if institution: Residence before
admission) <u>Maryland</u> | | 13b. COUNTY
<u>Caroline</u> | | 13c. CITY OR TOWN
<u>Federalsburg</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>Houston Branch Road</u> |
| 14. FATHER'S NAME
First <u>Joseph</u> | | Middle <u>Hrynko</u> | | Last <u></u> | | 15. MOTHER'S MAIDEN NAME
First <u>Katherine</u> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <u>no</u> | | 16b. SOCIAL SECURITY NO.
<u>220-52-7934</u> | | 17. INFORMANT
Address <u>Mrs. Mary Passwaters, Federalsburg, Md., RFD</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>403 X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>arteriosclerotic renal disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>1 month</u>
<u>5 yrs.</u> | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-2</u> , 19 <u>69</u> , to <u>5-7</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>5-6</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
<u>Stephen P. Carney</u> | | | | DEGREE
<u>M.D.</u> | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>Stephen P. Carney, M.D.</u> | | | | 22e. ADDRESS
<u>Easton, Md. 21601</u> | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<u>May 10, 1969</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Our Lady of Good Counsel</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Secretary, Maryland</u> | | |
| 24. FUNERAL DIRECTOR
<u>Frankton Funeral Home</u> | | | | ADDRESS
<u>Federalsburg, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAY 9 1969</u> | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07503

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07495

| | | | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|---|------------------------|--|
| 1. DECEASED-NAME
(Type or print) Edward Page JONES | | | 2a. DATE OF DEATH
Month 5 Day 7 Year 1969 | | | 2b. HOUR
4:40 M | | | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
SEPT 1, 1908 | | 6. AGE (In years lost birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Talbot Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
PAINTER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MD | | | 13b. COUNTY CAROLINE | | | 13c. CITY OR TOWN
RIDGELY | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
First HERBERT Middle JONES Last JONES | | | 15. MOTHER'S MAIDEN NAME
First RENA Middle MOORE Last MOORE | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT
MRS R. PAGE JONES Address RIDGELY MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple emboli (arterial) - aortic
4109
DUE TO, OR AS A CONSEQUENCE OF Bifurcation, renal, cerebral
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) acute myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF
(c) arteriosclerotic heart disease | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5-1-69
4-12-69
Uncertain | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
none | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-12 , 19 69 , to 5-7 , 19 69 , that (I) (we) last saw the deceased alive on 5-6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Robert W. Trever, M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-7-69 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
May 10, 1969 | | | 23c. NAME OF CEMETERY OR CREMATORY
RIDGELY | | | 23d. LOCATION (City or Town) (County) (State)
RIDGELY CAR. MD. | | |
| 24. FUNERAL DIRECTOR
CHARLES V. MOORE | | | ADDRESS
DENTON, MD. | | | 25a. REC'D BY REGISTRAR
MAY 13 1969 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

07503



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

VR 15
45M - 1969

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|--|--|--|--|
| 07504 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 07496 | |
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | 2a. DATE OF DEATH Month Day Year | |
| Oliver Herman Jones | | | | MAY 18 1969 3:35 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| male | | white | | 3/6/89 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| MD | | USA | | 9. COUNTY OF DEATH TALBOT | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | |
| EASTON | | Memorial Hosp. TALBOT | | WOOD CRAFTSMAN | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MD | | TALBOT | | EASTON | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | |
| JOSEPH H. JONES | | MARTHA WARNER | | 16b. SOCIAL SECURITY NO. 213-03-9025 | |
| 17. INFORMANT Address | | EMORY O. JONES, CROFTON, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.9 Cerebral Thrombosis | | | | 3 days | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7 July 1967, to 18 May 1969, that (I) (we) last saw the deceased alive on 18 May 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Thurston Harrison M.D. | | | | 22c. DATE SIGNED 20 May 69 | |
| 22d. PHYSICIAN'S NAME (Type) THURSTON HARRISON | | | | 22e. ADDRESS Easton Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| BURIAL | | 5/20/1969 | | SPRING HILL | |
| 24. FUNERAL DIRECTOR | | 23d. LOCATION (City or Town) (County) (State) | | 25a. REC'D BY REGISTRAR | |
| Merrilee E. Vennemann | | EASTON, MD. | | MAY 21 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4123

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|--|--|---|--|---|--|---|--|
| 07505 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07497 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
Ruth May Kees | | | 2a. DATE OF DEATH
Month Day Year
MAY 15 1969 | | | 2b. HOUR
7:58 M | |
| 3. SEX
Female | | 4. RACE
white | | 5. DATE OF BIRTH
08-10-02 | | 6. AGE (In years last birthday)
66 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
TA/bot | |
| 10. CITY OR TOWN OF DEATH
EASTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
DOMESTIC | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Caroline | | 13c. CITY OR TOWN
Preston | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER | | 14. FATHER'S NAME
First Middle Last
George KNAUEA | | 15. MOTHER'S MAIDEN NAME
First Middle Last
HARRIETTE Jeter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
578-12-2950 | | 17. INFORMANT
Address
Elmore R. Kees Preston, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4123 Congestive heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic heart disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>lost.</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
7 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-13</u> , 19 <u>69</u> , to <u>5-15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Stephen P. Canary | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-16-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 17, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hills | | 23d. LOCATION (City or Town) (County) (State)
Prince Georges Co. Md. | |
| 24. FUNERAL DIRECTOR
Maurice E. Newman & Son Easton Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1969 | | 25b. REGISTRAR'S SIGNATURE
J. J. J. Judge | |

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THIS CASE IS OPEN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07506

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07498

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|---|---|---|------------------------|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Sharon</i> | | | First | Middle | Last | 2a. DATE OF DEATH
Month <i>5</i> Day <i>3</i> Year <i>1969</i> | | | 2b. HOUR
<i>1:53 A.M.</i> | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>7-5-1894</i> | | 6. AGE (In years last birthday)
<i>74</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>OHIO</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Talbot</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>House in The Times</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>OSL DIST. REP.</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>OSL</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i> COUNTY <i>CHARLOTTE</i> | | | 13b. CITY OR TOWN
<i>DENTON</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| 14. FATHER'S NAME
First <i>WILLIAM</i> Middle <i>KRABILL</i> Last <i>FLORENCE</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>FLORENCE</i> Middle <i>BOSSERMAN</i> Last <i>BOSSERMAN</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <i>no</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address <i>MRS. S. HAVEL KRABILL, DENTON</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Hodgkins lymphoma</i>
<i>201X</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 year</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>25 April, 1969</i> , to <i>3 May, 1969</i> , that (I) (we) saw the deceased alive on <i>30 Apr</i> 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <i>(did)</i> (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Thorston Harrison M.D.</i> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>4 May 69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>THURSTON HARRISON</i> | | 22e. ADDRESS
<i>Easton Maryland</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, SPECIMEN
<i>Removal</i> | | 23b. DATE
<i>MAY 6, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>DENTON</i> | | | | 23d. LOCATION (City or Town) (County) (State)
<i>DENTON CAR. MD.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Charles Moore Denton</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 9 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

4369

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|---|---|--------|---|---|--|
| 07507 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07499 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | |
| HERMAN | | | T. | | LANKFORD | Month | Day |
| | | | | | | Year | 1969 |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) |
| male | | | white | | Feb. 4, 1897 | | 72 RS. |
| 7a. BIRTHPLACE (State or foreign
country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH |
| Maryland | | | U.S.A. | | | | Ta 1601 |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired) | |
| Easton | | | Memorial | | | masonry work | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| Md. | | | Caroline | | Federalburg | | 13e. STREET AND NUMBER |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| Charles Henry | | | Lankford | | | Laura Belle Williamson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | |
| yes | | | W. V. I. | | 217-01-8055 Mrs. Mildred Lankford | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY: | | | 3 days | | | | |
| IMMEDIATE CAUSE (a) <u>431.9</u> <u>Hypertensive pneumonia</u> | | | 5/16/69 | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) <u>Cerebral hemorrhage</u> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) <u>Previous stroke 2 yrs ago</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/16</u> , 19 <u>69</u> , to <u>5/21</u> , 19 <u>69</u> , that (I) (we) last
saw the deceased alive on <u>5/16</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | |
| J.T.B. Ambler M.D. | | | 5/22/69 | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | 22e. ADDRESS | | | | |
| J.T.B. Ambler, M.D. | | | Easton Maryland 21601 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | 5/25-69 | | Hillcrest Cem. | | Federalburg, Md. |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| H. W. Williams | | | Federalburg, Md. | | MAY 29 1969 | | Charles Judge |

05203



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May 2, 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|--|---|--|---|--|--|--|
| 07508 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07500 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Catherine Bruce Linthicum</i> | | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>16</i> Year <i>1969</i> | | | 2b. HOUR
<i>10:12 PM</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>12-19-85</i> | | 6. AGE (In years last birthday)
<i>83</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Talbot</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>House in The Pines</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Registrar Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Education</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Easton</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First <i>Christopher W.</i> Middle <i>Matthews</i> Last <i>Matthews</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Margaret</i> Middle <i>Wagh</i> Last <i>Wagh</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <i>No</i> | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Address <i>Mrs. Ethel Uber Easton, Md</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cachexia</i>
<i>437.9</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Chronic brain syndrome</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cerebral arteriosclerosis</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Uncertain</i>
<i>Uncertain</i>
<i>Uncertain</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>None</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-15-69</i> , 19 <i>69</i> , to <i>5-16</i> , 19 <i>69</i> , that (I) (we) lost the deceased alive on <i>5-14</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Robert W. Trever</i> M.D.
DEGREE | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-18-69</i> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>5/20/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gravely Road</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Pikesville Balto. Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Mitchell Alexander</i> | | | | 25a. REC'D BY REGISTRAR
<i>May 22 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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UNITED STATES

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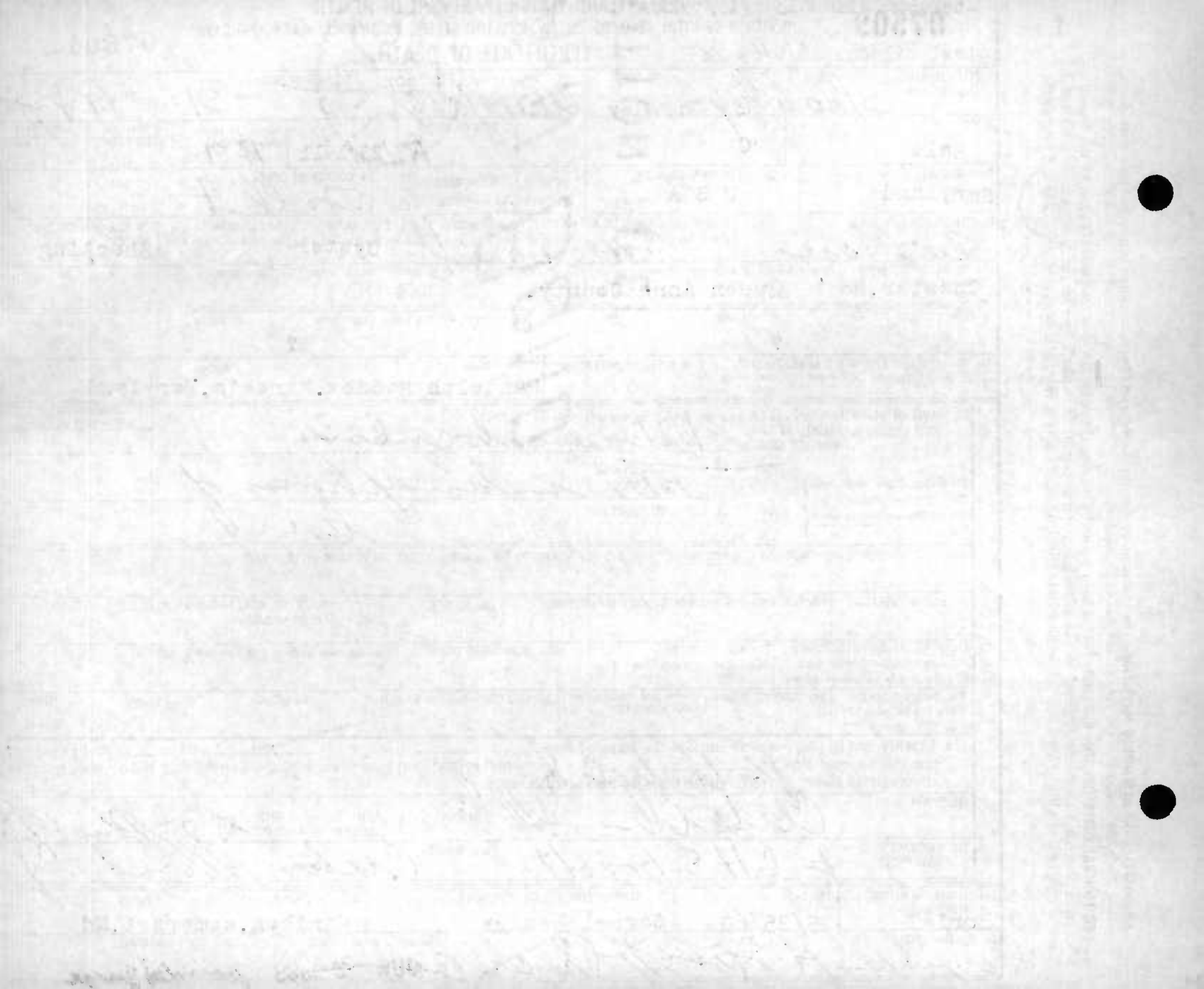
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | |
| Shandley | | Shandley | | Tullock | | Maddox | | 5 Month 21 Day Year 69 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | C | | 1/7/23/1911 | | 28 51 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U S A | | | | Zachary | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Easton | | Memorial | | Oyster | | Shucking | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Chester, Md | | Queen Anne County, | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| | | ? | | | | | | ? | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| | | | | Randolph Maddox | | Manokin, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Delirium tremens
2910
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Fatty metamorphosis of liver
(c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| E. C. H. Schmidt | | 22 May 69 | | E. C. H. Schmidt | | Caton, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 5/25/69 | | Samuel Wesley | | Manokin, Somerset, Md | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| William H. Jones | | JUN 2 1969 | | Charles Judge | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|--|---|---|--------------|---|--|
| <div> <div>07510</div> <div>07502</div> </div> | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| SARA ANN McHARG | | | | | | <input checked="" type="checkbox"/> Month 5 Day 14 Year 69 | | c7P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| Female | White | July 8, 1923 | 45 YRS | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 2d. HOUR |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Arkansas | | USA | | | | Talbot County Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| St. Michaels | | | ----- | | | Housewife | | ----- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | | Talbot | | | St. Michaels | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 13e. STREET AND NUMBER | | | |
| Clifford L. Holland | | | Katheryne Wingfield | | | --- | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| No | | | ----- | | | Beverly Henry K. McHarg, III, St. Michaels, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Synergistic alcohol-barbiturate | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF intoxication | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| Louis S. Welty | | | M.D. | | | 5-16-69 | | | |
| EXAMINER'S NAME (Type) | | | ACTING | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| LOUIS S. WELTY, M. D. | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | May 18, 1969 | | Rose Hill Cemetery | | Hope, Arkansas | | | |
| 24. FUNERAL DIRECTOR | | | 25. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Stanton E. Leonard, St. Michaels, Md. | | | DATE MAY 19 1969 | | | Charles Judge | | | |

05210

PHYSICAL EXAMINATION & TREATMENT OF DENTAL

DIVISION OF PUBLIC HEALTH

| | | | |
|----------------------|--|-----------------------|--|
| PATIENT'S NAME | | DATE | |
| SEX | | AGE | |
| RACE | | ETHNICITY | |
| ADDRESS | | CITY | |
| STATE | | ZIP | |
| OCCUPATION | | EDUCATION | |
| MARITAL STATUS | | RELIGION | |
| PAST MEDICAL HISTORY | | CURRENT MEDICATIONS | |
| ALLERGIES | | SOCIAL HISTORY | |
| FAMILY HISTORY | | PSYCHOLOGICAL HISTORY | |
| PHYSICAL EXAMINATION | | DENTAL EXAMINATION | |
| LABORATORY TESTS | | TREATMENT PLAN | |
| PROGRESS NOTES | | PATIENT SIGNATURE | |
| DENTIST SIGNATURE | | DATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 07511 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07503 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Edna Williams Moore</i> | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>30</i> Year <i>69</i> | | | 2b. HOUR
<i>PM 11:20</i> | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>1-20-81</i> | | 6. AGE (In years last birthday)
<i>88</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Talbot</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>House In The Pines</i> | | 12a. USUAL OCCUPATION (Kind of work done during life, even if retired.)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i></i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. CITY OR TOWN
<i>Dorchester</i> | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>302 Belvedere Ave.</i> | |
| 14. FATHER'S NAME
First <i>William</i> Middle <i>Applegarth</i> Last <i>Hubbard</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Laura</i> Middle <i>Hubbard</i> Last <i>Hubbard</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>213-03-9633</i> | | 17. INFORMANT
Address
<i>D Mr. Wm.H. Moore Talbot Ave. Camb.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>4339</i> IMMEDIATE CAUSE (a) <i>Central Thrombosis</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>9 days</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/4</i> , 19 <i>67</i> , to <i>5/30</i> , 19 <i>69</i> , that (I) (<i>we</i>) last saw the deceased alive on <i>5/28</i> , 19 <i>69</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the causes stated above, (I) (<i>we</i>) (<i>did</i>) (<i>did not</i>) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Wm H Harrison</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>31 May 69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>HARRISON HARRISON</i> | | | | 22e. ADDRESS
<i>Easton Maryland</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>6/2/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Dorchester Mem. Park</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Cambridge Dorchester Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>Robert F Thomas Jr</i> | | | | ADDRESS
<i>Cambridge Md. 21610</i> | | 25a. REC'D BY REGISTRAR
DATE <i>JUN 4 1969</i> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>J Charles Judge</i> | |

07511

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07512

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07504

| | | | | | | | | | | |
|---|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
Emmett Bryon Morton, Jr | | | 2a. DATE OF DEATH Month Day Year
May 23 1969 | | | 2b. HOUR
4:35 PM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
8/31/1888 | | 6. AGE (In years lost birthday)
80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Talbot Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
POSTAL EMPLOYEE | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
TALBOT | | 13c. CITY OR TOWN
EASTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
609 SOUTH ST. | |
| 14. FATHER'S NAME First Middle Last
Emmett B. Morton, Sr | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Annie Elston | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | | 16b. SOCIAL SECURITY NO.
813-01-8448 | | 17. INFORMANT Address
Mrs. E.B. Morton, Easton, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>HYPERTENSION</u>
<u>401X</u> DUE TO, OR AS A CONSEQUENCE OF
(b) <u>RENAL ARTERY STENOSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 15</u> , 19 <u>68</u> , to <u>MAY 23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>April 19</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
C. W. Brain | | DEGREE
CRW Brain | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/26/69 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
C. W. Brain | | 22e. ADDRESS
210 Dover, Easton, Md | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
5/27/1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill | | 23d. LOCATION (City or Town) (County) (State)
EASTON, MD | | | | |
| 24. FUNERAL DIRECTOR
Maurice K. K... .. | | ADDRESS
Easton, Md | | 25a. REC'D BY REGISTRAR
MAY 28 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

1900

1

07513

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07505

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|--|---|
| 1. DECEASED NAME
(Type or print) First <i>Austin</i> Middle <i>Ray</i> Last <i>Murphy Sr.</i> | | | 2a. DATE OF DEATH
5 Month Day 31 Year 69 | | 2b. HOUR
3p M |
| 3. SEX
<i>M</i> | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>NOV. 11, 1896</i> | 6. AGE (In years
last birthday)
<i>72</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
<i>MD</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
<i>TALBOT</i> | | |
| 10. CITY OR TOWN OF DEATH
<i>EASTON</i> | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Memorial Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life even if retired.)
<i>SALES MAN</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>AUTO</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>MD</i> | 13b. COUNTY
<i>VENTNOLINE</i> | 13c. CITY OR TOWN
<i>DENTON</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME
First <i>CHARLES</i> Middle <i>MURPHY</i> Last | | 15. MOTHER'S MAIDEN NAME
First <i>SARA H</i> Middle <i>LEWIS</i> Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service)
<i>NO</i> | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT
<i>MRS. AUSTIN MURPHY, DENTON</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>4123</i> IMMEDIATE CAUSE (a) <i>Coronary heart failure</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic rheumatic heart disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>(?)</i> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>1 wk</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-14</i> , 19 <i>68</i> , to <i>31 May</i> , 19 <i>69</i> , that (I) (we) last
saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Thurston Harrison M.D.</i> | | DEGREE | ATTENDING
PHYS. | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
<i>1 June 69</i> |
| 22d. PHYSICIAN'S
NAME (Type) <i>THURSTON HARRISON</i> | | 22e. ADDRESS <i>EASTON MARYLAND</i> | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | 23b. DATE
<i>JUNE 3, 1969</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>DENTON</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>DENTON CAR. MD.</i> | |
| 24. FUNERAL DIRECTOR
<i>More & Son</i> | | ADDRESS
<i>Denton MD</i> | | 25a. REC'D BY REGISTRAR
DATE <i>JUN 3 1969</i> | 25b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-74
ASM 7-69

STATE OF OHIO
DEPARTMENT OF REVENUE

IN SENATE,
January 1, 1911.
REPORT
OF THE
COMMISSIONER OF REVENUE
FOR THE YEAR
1910.
COLUMBUS:
THE STATE PRINTING OFFICE,
1911.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07514 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07506 | |
|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) <u>EVERLYN ROSANNA NIXON</u> | | | | | 2a. DATE OF DEATH <u>May 23 1969</u> | | 2b. HOUR <u>1:30</u> M |
| 3. SEX <u>Female</u> | 4. RACE <u>Negro</u> | | 5. DATE OF BIRTH <u>MAY 25 1921</u> | | 6. AGE (In years lost birthday) <u>48</u> YRS. | IF UNDER 1 YEAR MONTHS | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <u>MD</u> | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>TALBOT</u> Md. | | |
| 10. CITY OR TOWN OF DEATH <u>Easton</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Domestic</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u> | | 13b. COUNTY <u>Talbot</u> | | 13c. CITY OR TOWN <u>Easton</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER <u>107 Blake St</u> | | 14. FATHER'S NAME First <u>Norma</u> Middle <u>Nixon</u> Last <u>Sarah</u> | | 15. MOTHER'S MAIDEN NAME First <u>Thomas</u> Middle <u>Camp</u> Last <u>Thomas</u> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>Yes, no, or unknown</u> | | 16b. SOCIAL SECURITY NO. <u>28-20-9568</u> | | 17. INFORMANT <u>Sarah Thomas</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> | | | | | | | <u>2 HOURS</u> |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>PLEURAL EFFUSION</u> | | | | | | | <u>1 WEEK</u> |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>OVARIAN CARCINOMATOSIS</u> | | | | | | | <u>7 months</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION <u>NONE</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>OCT. 28, 1969</u> , to <u>MAY 23, 1969</u> , that (I) (we) last saw the deceased alive on <u>MAY 22, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>John A. Hawkinson MD</u> | | | | 22c. DATE SIGNED <u>5-23-69</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>John A. Hawkinson, M.D.</u> | | | | 22e. ADDRESS <u>11 Earle Ave. Easton, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>5/27/69</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Windsor</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Talbot</u> | |
| 24. FUNERAL DIRECTOR <u>Gene H. Russell Easton MD</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| DATE <u>MAY 28 1969</u> | | | | | | | |

Franklin D. Roosevelt
SIX
Mr. Tolson
Dear Mr. Tolson:

Enclosed for you are
two copies of a letter
from the American
People's Committee
for the Liberation
of the Peoples of
Russia.

I am sure that you
will find it of
interest. I am
very truly,
Sincerely,
John A. B. Robinson, Jr.

John A. B. Robinson, Jr.
11 Maple Ave. Boston, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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07515

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07507

| | | | | | | | | | | | | |
|---|--|---|---|---|---|---|---|---|---|--|-------|--|
| 1. DECEASED-NAME
(Type or print) <i>Mary U Pektel</i> | | | 2a. DATE OF DEATH
Month <i>5</i> Day <i>2</i> Year <i>69</i> | | | 2b. HOUR
<i>12A</i> M | | | | | | |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
<i>APRIL 27-1898</i> | | 6. AGE (In years last birthday)
<i>71</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>PENNA.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Tallot</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>HOUSEWIFE</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>x x</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MARYLAND</i> | | 13b. COUNTY
<i>QUEEN ANNE</i> | | 13c. CITY OR TOWN
<i>STEVENSVILLE</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Love Point</i> | | | | |
| 14. FATHER'S NAME
First <i>JACOB</i> Middle <i>PRICE</i> Last <i>PRICE</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>ELLA</i> Middle <i>AINSWORTH</i> Last <i>AINSWORTH</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>No</i> | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>214-18-0385</i> | | 17. INFORMANT
Address <i>MRS. RUTH LEONARD-STEVENSVILLE MD.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>lymphosarcoma</i>
<i>2001</i> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Jan. 1969</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-10</i> , 19 <i>69</i> , to <i>5-2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-1-</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert W. Trever</i> M.D. | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-3-69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i> | | | | | M.D. | | 22e. ADDRESS
<i>Easton, Maryland 21601</i> | | 5/3/69 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>MAY 5</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>STEVENSVILLE</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>STEVENSVILLE G.A. MD.</i> | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Have Funeral Home, Church Hill, Md.</i> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 7 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>William J. Jones</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 07516 | | | | | | | | | | | |
| 07508 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
<i>Dadie</i> | | Middle
<i>G.</i> | | Last
<i>Plutschak</i> | | 2a. DATE OF DEATH
Month <i>May</i> Day <i>2</i> Year <i>1969</i> | | 2b. HOUR
<i>12</i> P. M. | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>8/17/1905</i> | | 6. AGE (In years last birthday)
<i>63</i> YRS. | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Germany</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>TALBOT</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>EASTON</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Lab. Asst. Talbot Co. Health Dept.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Easton</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>112 Talbot St.</i> | | | |
| 14. FATHER'S NAME
First <i>Frank</i> Middle <i>Saathoff</i> | | | | 15. MOTHER'S MAIDEN NAME
First <i>Hilka</i> Middle <i>Jelden</i> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
<i>267-36-2079</i> | | | | 17. INFORMANT
<i>August R. Plutschak, Easton, Md.</i> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
<i>1950</i> IMMEDIATE CAUSE (a) <i>Abdominal sarcomatosis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>—</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sept. 1968</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>none</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>69</i> , to <i>5-2</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5-2</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert W. Trever</i> M.D. | | | | 22c. DATE SIGNED
<i>5-3-69</i> | | | | 22d. PHYSICIAN'S NAME (Type)
<i>Robert W. Trever</i> M.D. | | | |
| 22e. ADDRESS
<i>Easton, Md. 21601</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>5/5/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn Memorial Park</i> | | 23d. LOCATION (City or Town)
<i>Easton, Md.</i> | | (County) (State) | | | |
| 24. FUNERAL DIRECTOR
<i>Maurice E. Newman</i> | | | | ADDRESS
<i>Son Easton, Md.</i> | | | | 25d. REC'D BY REGISTRAR
<i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |
| DATE
<i>MAY 6 1969</i> | | | | | | | | | | | |

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[illegible]

2162 F. J. M. J. . . .

573-X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 07517 | | | | | | | | | |
| 07509 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR a |
| Mary Barbara Pospeshill | | | | | | 5 Month 11 Day 69 Year | | | 12:30 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| female | | white | | 7-2-89 | | 79 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Czechoslovakia | | U.S.A. | | | | Talbot Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Easton | | | House In The Pines | | | none | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md | | | Dorchester | | | Hurlock | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Joseph Holecheck | | | Barbara Vojtisek | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| No | | | | | | Mrs. Jerome Thomas, Hurlock, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Subacute cholecystitis</u> | | | | | | | | | 7 weeks |
| 575 X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| <u>Generalized and cerebral arteriosclerosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>4-13</u> , 19 <u>69</u> , to <u>May 11</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 9</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| <u>Stephen P. Carney</u> | | May 12, 1969 | | Stephen P. Carney, M.D. | | | | | |
| 22e. ADDRESS | | 22f. REC'D BY REGISTRAR | | | | | | | |
| P.O. Box 929, Easton, Md. 21601 | | 9 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 25b. REGISTRAR'S SIGNATURE | |
| Burial | | 5/13/69 | | Our Lady of Good Counsel | | Secretary Dor. Md. | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Kath. S. Hollingsworth, East New Market | | MAY 14 1969 | | 9 | | | | | |

180X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07518

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07510

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|-------------------------------------|--|---|--|--|---|---|-----------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Mary Elizabeth Rich | | | 2a. DATE OF DEATH
Month Day Year
May 7 1969 | | | 2b. HOUR
4A M | | | | | |
| 3. SEX
F | | 4. RACE
N | | 5. DATE OF BIRTH
MAR. 12, 1908 | | 6. AGE (in years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Talbot Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
RST 150 MB | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD | | | 13b. COUNTY
WISCONSIN | | 13c. CITY OR TOWN
DENTON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First Middle Last
HOWARD BROOKS | | | 15. MOTHER'S MAIDEN NAME First Middle Last
SARAH GROCE | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. JAS. BROWN | | | Address
DENTON, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pyrexia
180X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Carcinoma of uterus, metastatic.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/6, 1969, to 5/7, 1969, that (I) (we) last saw the deceased alive on 5/6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Justin T. Callahan MD | | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5/8/69 | |
| 22d. PHYSICIAN'S NAME (Type)
JUSTIN T. CALLAHAN | | | | | | 22e. ADDRESS
BOX 1208 EASTON | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE
May 11, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
SPRING GROVE | | | 23d. LOCATION (City or Town) (County) (State)
DENTON CAR. MD. | | | |
| 24. FUNERAL DIRECTOR
Charles W. Moore | | | | | | ADDRESS
Denton | | 25a. REC'D BY REGISTRAR
DATE
MAY 13 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

03518



[Faint, illegible text covering the majority of the page, possibly bleed-through from the reverse side.]

[Faint, illegible text in the right margin, possibly bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07519

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07511

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|---|--|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Louis Jacob Roch | | | 2a. DATE OF DEATH
5 Month 21 Day 69 Year 830 AM | | | 2b. HOUR | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUG. 20 1899 | | 6. AGE (In years lost birthday)
69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
LATROBE PA. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
TALBOT Md. | | | |
| 10. CITY OR TOWN OF DEATH
EASTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
STEAM FITTER | | 12b. KIND OF BUSINESS OR INDUSTRY
RETIRED | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. CITY
STEVENSVILLE | | 13c. CITY OR TOWN
TALBOT | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
MANROE MANOR Rd | |
| 14. FATHER'S NAME
First Middle Last
Louis ROCH | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
LOUISE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (name and rank) (If yes give war or dates of service)
NO | | 16b. SOCIAL SECURITY NO.
218055104 | | 17. INFORMANT
SOPHIA E ROCH | | Address
MANROE MANOR Rd | | City
MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage of lung
1621 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Pneumonia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) (do not) (do not) the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E. C. H. Schmidt | | DEGREE
MD | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
21 Aug 69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
E. C. H. Schmidt | | 22e. ADDRESS
Easton, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MAY 24, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
MORELAND MEM. PK Cem. | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MARYLAND | | | |
| 24. FUNERAL DIRECTOR
Maurice E. Newman-Son | | ADDRESS
Easton, Md. | | 25a. REC'D BY REGISTRAR
23 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | |

1934

[Faint, illegible handwriting on lined paper]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07520

CERTIFICATE OF DEATH

07512

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last
<i>Estel May Roe</i> | | | 2a. DATE OF DEATH Month Day Year
<i>May 2 1969</i> | | 2b. HOUR
<i>1300</i> |
| 3. SEX
<i>FEMALE</i> | | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
<i>12/4/1899</i> | | 6. AGE (In years last birthday) YRS.
<i>69</i> |
| 7a. BIRTHPLACE (State or foreign country)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
<i>Talbot</i> | | Md. | | | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housework</i> | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>TALBOT</i> | | 13c. CITY OR TOWN
<i>EASTON</i> | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>110 CHOPTANK</i> | | | |
| 14. FATHER'S NAME First Middle Last
<i>JAMES F. CHEEZUM</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>ANNIE SIGMAN</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>220-320443</i> | | 17. INFORMANT Address
<i>JAMES W. ROE, EASTON, MD.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>18 hours</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Dislike</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>64</i> , to <i>2 May</i> , 19 <i>69</i> , that (I) (we) lost the deceased on <i>2 May</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Stephen P. Carney</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-6-69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Stephen P. Carney</i> | | M. D. | | 22e. ADDRESS
<i>Easton, Maryland 21601</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>5/5/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>JUNIOR ORDER</i> | |
| 23d. FUNERAL DIRECTOR
<i>Maurice E. Neumann - Son Easton, Md</i> | | ADDRESS | | 23e. LOCATION (City or Town) (County) (State)
<i>PRESTON, MD</i> | |
| 24. REC'D BY REGISTRAR
<i>MAY 8 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>William J. Judge</i> | | | |

IN SENATE,

JANUARY 11, 1870.

REPORT OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE,

FOR THE YEAR 1869.

BY J. W. WALKER, CLERK OF THE SENATE.

RECEIVED AT THE OFFICE OF THE CLERK OF THE SENATE,

AT DALLAS, TEXAS, JANUARY 11, 1870.

BY THE CLERK OF THE SENATE,

J. W. WALKER.

CLERK OF THE SENATE.

AT DALLAS, TEXAS.

1870.

PRINTED BY J. W. WALKER,

CLERK OF THE SENATE,

AT DALLAS, TEXAS.

1870.

BY THE CLERK OF THE SENATE,

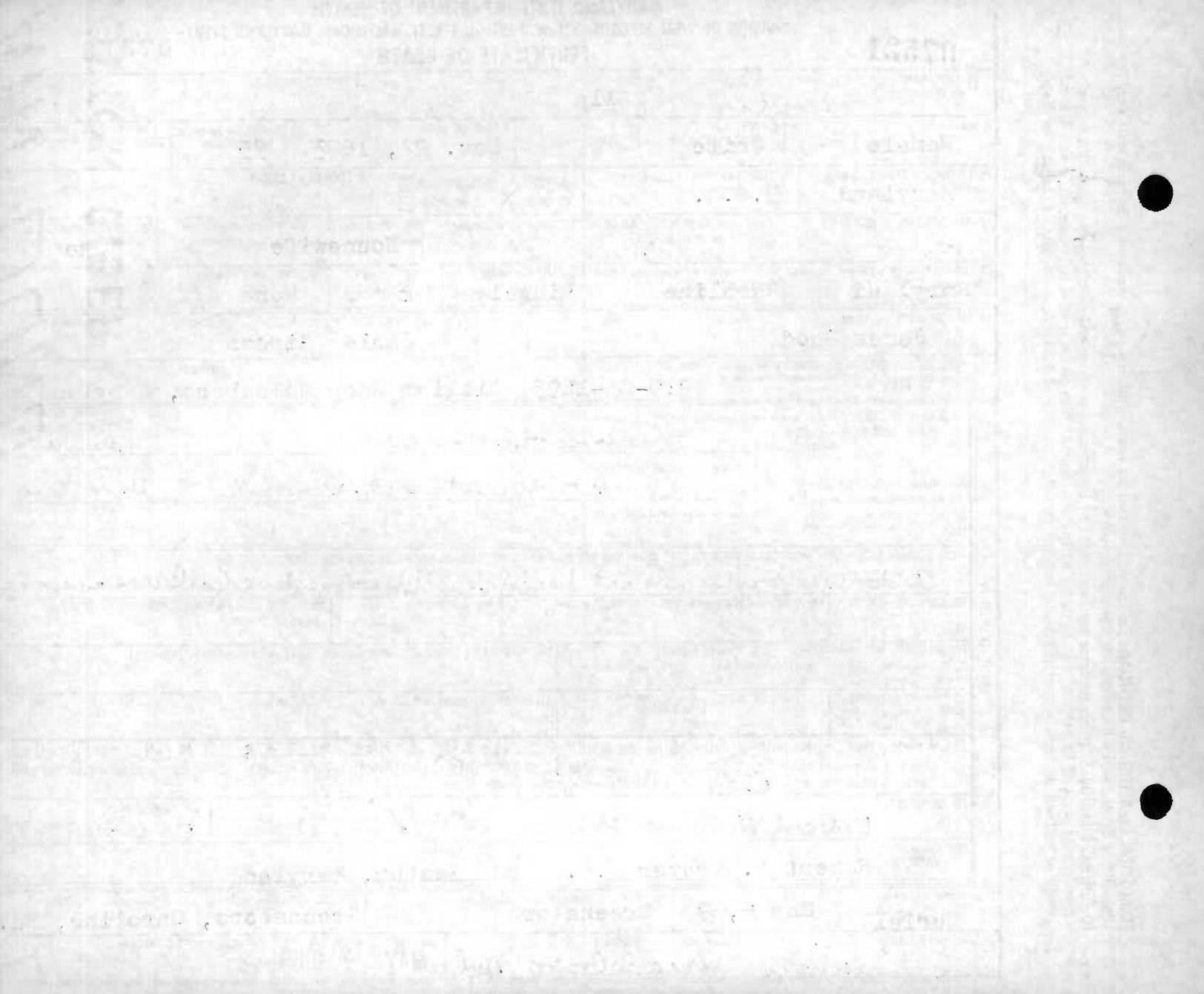
J. W. WALKER.

CLERK OF THE SENATE.

4339
X
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14
45M - 1969

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|---|---|--|--------------------------------|--|
| 07521 | | | | | 07513 | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | | |
| First Middle Last
Laura Ella Roop | | | | | Month Day Year
5 3 1969 | | | | |
| 2b. HOUR
10:30 M | | | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Nov. 22, 1893 | | 6. AGE (In years last birthday)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Tappah | | | |
| 10. CITY OR TOWN OF DEATH
Easton | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE
Maryland | | 13b. COUNTY
Caroline | | 13c. CITY OR TOWN
Ridgely | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
None | |
| 14. FATHER'S NAME First Middle Last
James Good | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Janie Gipson | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | | | 16b. SOCIAL SECURITY NO.
219-03-1895 | | | | |
| | | | | | 17. INFORMANT Address
William Roop Goldsboro, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>
4339 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Uncertain</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Arteriosclerotic heart disease with congestive failure + anasarca</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-24</u> , 19 <u>69</u> , to <u>5-3</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>5-3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert W. Trever, M.D. | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-3-69 | | |
| 22d. PHYSICIAN'S NAME (Type)
Robert W. Trever M.D. | | | | | 22e. ADDRESS
Easton, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 6, 69 | | 23c. NAME OF CEMETERY OR CREMATORY
Greensboro | | 23d. LOCATION (City or Town) (County) (State)
Greensboro, Caroline, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
F. E. Boulain Greensboro, Md | | | | | 25a. REC'D BY REGISTRAR
DATE MAY 7 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | | |



4319

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07522

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07514

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|-------------------------------|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Margaret M. Rowens</i> | | | First Middle Last | | | 2a. DATE OF DEATH
5 Month 23 Day 1969 | | | 2b. HOUR
10 ¹⁰ AM | | | | | | | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
4/11/1887 | | | 6. AGE (In years last birthday)
82 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Talbot</i> Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>St. Michaels (Rural)</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Rio Vista Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housework</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY
<i>Talbot</i> | | | 13c. CITY OR TOWN
<i>Easton</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>Primrose House</i> | | | | | |
| 14. FATHER'S NAME
<i>John R. Mullikin</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
<i>Mary Chaplain</i> | | | First Middle Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>no</i> | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>220-46-2345</i> | | | 17. INFORMANT
<i>Mrs. Charlotte Toontz, Greensboro, N.C.</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Massive Cerebral Hemorrhage</i>
<i>4319</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cerebral atherosclerosis.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1/2 HR</i>
<i>4 hrs</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Diabetes Mellitus</i> | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION, Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/11</i> , 19 <i>69</i> , to <i>Feb. 1</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>Feb. 1</i> , 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>S. KRECH</i> | | | DEGREE
<i>MD.</i> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>5/26/69</i> | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>S. KRECH, JR.</i> | | | 22e. ADDRESS
<i>EASTON, MD.</i> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>5/26/1969</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Spring Hill</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Easton, Md.</i> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>MAURICE E. NEUNAM & SON, Easton, Md.</i> | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 27 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | | |

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Unpublished (1987) 1/1/1987

Unpublished (1987) 1/1/1987

Unpublished (1987) 1/1/1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 07523 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07515 | |
| 1. DECEASED-NAME (Type or print) MARY MAGDALENE SHORTALL | | | | | | 2a. DATE OF DEATH MAY 25 1969 | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH December 16, 1883 | | 6. AGE (In years last birthday) 85 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH QUEEN ANNE TALBOT Md. | |
| 10. CITY OR TOWN OF DEATH QUEEN ANNE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) TALBOT | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY None | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) MARYLAND | | 13b. TALBOT | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME Phillip Bunn | | 15. MOTHER'S MAIDEN NAME Stephanie Weiler | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 216-54-9084 | |
| 17. INFORMANT DAUGHTER | | 18. ADDRESS Miss Marie Shortall, Queenstown Md. | | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma of the lungs
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of the rectum
DUE TO, OR AS A CONSEQUENCE OF (c) 1 year | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) Arteriosclerosis obliterans with bilat. amputation of the legs | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Kurt Lederer M.D. | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 6/3/69 | | | |
| 22d. PHYSICIAN'S NAME (Type) KURT LEDERER | | 22e. ADDRESS QUEEN ANNE MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE MAY 28, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery | | 23d. LOCATION (City or Town) (County) (State) Queenstown D.A. Co. Md. | |
| 24. FUNERAL DIRECTOR James H. Bunting | | ADDRESS Benton Box, Centerville, Md. | | 25a. RECEIVED BY REGISTRAR JUN 5 1969 | | 25b. REGISTRAR'S SIGNATURE James H. Bunting | |

032528

UNITED STATES OF AMERICA

~~SECRET~~

Metastasis carcinoma of the liver
carcinoma of the rectum
1960

Metastatic carcinoma with histopathology of the lung

KURT LEONARD
MD
KURT LEONARD MD

QUEEN ANNE MD
6/3/60

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07524

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07516

| | | | | | |
|---|------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Queen Ann | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Trappe | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Grasonville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
27 North Street | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) William Martin Smith | | | 4. DATE OF DEATH
Month 5 Day 18 Year 1969 | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/25/1880 | | 9. AGE (In years last birthday) 88 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 13. FATHER'S NAME
Joseph J. Smith | | | 14. MOTHER'S MAIDEN NAME
Lillian Brooks | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
213-48-3112 | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Senility
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO
(c) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Lane Phoebe | | M.D.
WIELTY Acty | | 22. DATE SIGNED
5-20-69 | |
| EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE THEREOF
5/20/69 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters | |
| 24. FUNERAL DIRECTOR
Lane Funeral Home, Church Hill, Maryland | | ADDRESS | | 23d. LOCATION (City or Town) (County) (State)
Queenstown, Q.A., Md | |
| | | 25a. REC'D BY REGISTRAR
DATE MAY 21 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

07123

Label

Labels

SV North Street

William Martin Baker

10/25/1980

USA

Virginia

William Baker

Joseph J. Baker

310-10-312

Washington, D.C., 20540

St. Francis

12/50/59

Label

WILLIAM MARTIN BAKER

Label: General Home, Church Hill, Maryland

5699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

07525

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07517

| | | | | | | | | | |
|--|------------------------------|--|---|--|--|---|--|----------------------------|------------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | |
| Robert | | | H. | Stafford, Jr. | Month | Day | Year | 10 ⁰⁵ M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Male | White | | Feb 26, 1917 | | 52 YRS. | | MONTHS | DAYS | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. COUNTY OF DEATH | | Md. | | |
| Maryland | U.S.A. | | <input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | Talbot | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Easton | | Memorial | | Farm machinery dealer | | Farm mach. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Del. | | Kent | | Harrington | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Central | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| Robert Henry | | | | Stafford, Jr. | Mary Thawley | | | | Stafford |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | 214-32-6822 | | Mrs. Lillian W. Stafford | | Hq. Del. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (b) <u>Diffuse cerebral damage</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>Shock due to gastrointestinal hemorrhage hypoglycemia</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(d) | | | | | | | | | |
| <u>Dilated, marginal ulcer.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | HOUR A.M. Month Day Year | | | | | | | |
| (If either, notify medical examiner) | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | | | |
| at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>18 Apr</u> , 19 <u>69</u> , to <u>6 May</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>6 May</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. | | 22c. DATE SIGNED | |
| <u>Joseph P. Camy</u> | | | | | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 5-6-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | 5/9/69 | | Denton Cemetery | | Denton | | Caroline Maryland | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>James Hampton Jr.</u> | | | | <u>Federalburg, Maryland</u> | | MAY 9 1969 | | <u>Charles Judge</u> | |

1955

RECEIVED



4122

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|
| 07526 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07518 | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| First Middle Last
Neva Corrine Tilghman | | | | | | Month Day Year
May 25 1969 | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | |
| Female | | Negro | | April 8, 1900 | | 69 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Talbot Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Easton | | Memorial | | Laborer | | None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Talbot | | Easton | | | | 54 Pleasant Street | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| First Middle Last
Henry Thomas | | First Middle Last
Nora Breeze | | | | 220 28 0657 | | Address Maryland | |
| | | | | | | Oscar Tilghman | | 54 Pleasant St. Easton | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-Pulmonary Failure</u>
<u>4122</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Cerebro-Vascular Accident</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertensive Cardio-Vascular Disease</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>36 Hours</u>
<u>36 Hours</u>
<u>10 Years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Carcinoma of Vulva 1960, Carcinoma of Endometrium 1967, Both Treated</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (dissection) attended the deceased from Dec 10, 1968, to May 23, 1969, that (I) (ex) saw the deceased alive on May 23, 1969, and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above, (I) (ex) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| John A. Hawkinson MD | | 5-25-69 | | John A. Hawkinson, M.D. | | | | | |
| 22e. ADDRESS | | 11 Earle Ave., Easton, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. REGISTRAR'S SIGNATURE | |
| Burial | | 5/28/69 | | Richards Memorial | | Easton Talbot Maryland | | Barbara L. Dashiell | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | DATE | | | |
| Barbara L. Dashiell | | MAY 29 1969 | | Charles Judge | | | | | |

04252



RECEIVED

NOV 1964

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180x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
45M - 1-69

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--------------------------------|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 07527 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 07519 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
MARY JANE TILLER | | | | | | | | | | 2a. DATE OF DEATH Month Day Year
5 16 69 | | | | | | | | | | 2b. HOUR
8:15 P M | | | | | | | | | |
| 3. SEX
FEMALE | | | 4. RACE
NEGROE | | | 5. DATE OF BIRTH
3/15/1906 | | | 6. AGE (In years last birthday)
63 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
TAIBOT Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
EASTON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
MEMORIAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housekeeper | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Caroline | | | 13c. CITY OR TOWN
Ridgely | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
None | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
William Tiller | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Mary Jane Daniel | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
218-07-7371 | | | 17. INFORMANT Address
Ida Tiller Ridgely, Maryland | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Inanition</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of cervix</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>180x</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year
P.M. 19 69 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>3-15-69</u> , to <u>5-16-69</u> , that (I) (we) lost saw the deceased alive on <u>5/16</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
J.T.B. Ambler | | | | | | | | | | DEGREE
M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | 22c. DATE SIGNED
5/19/69 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
J.T.B. Ambler | | | | | | | | | | 22e. ADDRESS
Easton, Maryland 21601 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 23b. DATE
5-20-69 | | | | | 23c. NAME OF CEMETERY OR CREMATORY
Union | | | | | 23d. LOCATION (City or Town) (County) (State)
Goldsboro, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Jm E Badley | | | | | | | | | | ADDRESS
Frederick Md | | | | | 25a. REC'D BY REGISTRAR
MAY 21 1969 | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | |

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UNITED STATES OF AMERICA

IN SENATE
January 1, 1900

REPORT
OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1899

AND

OF THE LANDS BELONGING TO THE UNITED STATES

IN THE TERRITORY OF ARIZONA

AND

OF THE LANDS BELONGING TO THE UNITED STATES

IN THE TERRITORY OF ARIZONA

AND

OF THE LANDS BELONGING TO THE UNITED STATES

IN THE TERRITORY OF ARIZONA

AND

OF THE LANDS BELONGING TO THE UNITED STATES

IN THE TERRITORY OF ARIZONA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07528

07520

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Hildred Virginia Toms</i> | | | First Middle Last | | 2a. DATE OF DEATH
5 Month 6 Day 1969 | | 2b. HOUR
7:45 AM | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
8/7/1919 | | 6. AGE (In years
49 birth day) | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Talbot</i> | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Wittman</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during 1 year preceding death)
<i>Storekeeper (general)</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Wittman</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME
<i>Warthman Sewell</i> | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME
<i>Cora Marshall</i> | | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
<i>no</i> (Yes go, or unknown) | | | 16b. SOCIAL SECURITY NO.
<i>216-40-4438</i> | | 17. INFORMANT
<i>Stanley Toms, Easton, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>cachexia</i>
<i>1538</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>carcinomatosis</i>
DUE TO, OR AS A CONSEQUENCE OF
<i>adenoca. colon</i>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>- Nov.</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>5-6</i> , 1969, that (I) (we) lost the deceased alive on <i>5-6</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>M. E. Neumann</i> | | | | | 22c. DATE SIGNED
<i>6-7-69</i> | | 22d. PHYSICIAN'S NAME (Type)
<i>Ray M. Reeser</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
<i>Burial</i> | | | | | 23b. DATE
<i>5/8/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Oliver</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>St. Michaels, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>MAURICE E. NEUNAM & SON, Easton, Md.</i> | | | | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 12 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

07522

Michael J. Smith

01/11/73

11/11/73

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|------------------------------|--|--|--|------------------------------------|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Perry | | | Trusty | | | May 23, 1969 | | | 5:15A |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| Male | Colored | | March 24, 1895 | | | 74 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. |
| Maryland | U.S.A. | | | | | Talbot | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Easton | | | Memorial | | | Laborer | | | Pharmacy |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Queen Anne's | | | Centreville | | 206 Little Kidwell | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Charles | | | Trusty | | | Catherine Ringgold | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| Yes | | | W.W. I | | | 215-01-5814 Abe Rozier, Jr., nephew, 227 N. Liberty St., Centreville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (subtotal gastrectomy)
(b) <u>Post-operative (splenectomy)</u>
DUE TO, OR AS A CONSEQUENCE OF (benign gastric)
(c) <u>Massive GI bleeding (ulcer)</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| None | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> , 19 <u>69</u> , to <u>5-23</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>5-22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Robert W. Trever M.D. | | | | | | 22c. DATE SIGNED
6-4-69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. Robert W. Trever, M.D. | | | | | | 22e. ADDRESS
Easton, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | May 27, 1969 | | Chesterfield Cemetery | | Centreville, Qu.An. Co., Md. | | |
| 24. FUNERAL DIRECTOR
James H. Barton, Jr.
Barton Bros., Centreville, Maryland | | | | | | 25a. REC'D BY REGISTRAR
JUN 5 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

07530

U.S. DEPARTMENT OF JUSTICE

RECEIVED JUL 23 1962

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

CLASSIFICATION: [Illegible]

REMARKS: [Illegible]

APPROVED: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 07530 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07522 | |
|---|--|--|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | |
| First <i>Anna</i> Middle <i>W</i> Last <i>Tull</i> | | | | | Month <i>5</i> Day <i>28</i> Year <i>1969</i> | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
3-5-96 | | 2b. HOUR
<i>6 am</i> | |
| 7a. BIRTHPLACE (State or foreign country)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 6. AGE (In years and birthday)
<i>73</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 10. CITY OR TOWN OF DEATH
EASTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
HOUSE IN THE PINES | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
TELEPHONE OPERATOR | | 12b. KIND OF BUSINESS OR INDUSTRY
CVP | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | 13b. COUNTY
<i>TALBOT</i> | | 13c. CITY OR TOWN
EASTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
<i>Philip Cooper</i> | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Katherine Willis</i> | | 13e. STREET AND NUMBER
103 SYCAMORE AVE. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (or, if unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>312-10-0250</i> | | 17. INFORMANT Address
<i>Wm. W. Tull, Easton, MD.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Chronic Congestive Heart Failure</i>
4123 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>months</i>
<i>yrs.</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>Thrombosis L. Middle Cerebral Artery - 3 d.</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/27/69</i> to <i>5/28/69</i> , that (I) (we) last saw the deceased alive on <i>5/27/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>S. Kreche Jr.</i> | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5/28/69</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>S. KRECHE JR.</i> | | 22e. ADDRESS
<i>EASTON, ME</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE
<i>5/30/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>OXFORD</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>OXFORD, MD</i> | |
| 24. FUNERAL DIRECTOR
<i>Maurice L. Newman - Son</i> | | ADDRESS
<i>Easton, MD</i> | | 25a. REC'D BY REGISTRAR
<i>MAY 29 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

4

89-2-3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15-1
45M - 11-69

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|--|--|--|--|---|--|---|--|---|--|
| 07531 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07523 | | | |
| 1. DECEASED-NAME (Type or print) <i>Maude Elizabeth Whitby</i> | | | | | | 2a. DATE OF DEATH
5 Month 7 Day 1969 | | 2b. HOUR
10 A. M. | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
6/29/1887 | | 6. AGE (In years last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Talbot</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Easton (rural)</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Grass Coate</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housework</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Easton</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>RF #1</i> | |
| 14. FATHER'S NAME First Middle Last
<i>William H. Wolf</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Hannah Turpin</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>217-54-5049</i> | | 17. INFORMANT
<i>Charles L. Whitby, Jr. Easton, Md.</i> | | | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Heart Failure</i>
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Recent Acute Myocardial Infarction</i> 6 wks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>7/16</i> , 19 <i>63</i> , to <i>5/7</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>5/6</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>S. K. RECH</i> | | DEGREE
<i>MD.</i> | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5-8-69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>S. K. RECH JR.</i> | | 22e. ADDRESS
<i>EASTON, Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Buried</i> | | 23b. DATE
<i>5/9/1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Spring Hill</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Easton, Md.</i> | | | |
| 24. FUNERAL DIRECTOR
<i>MURPHY E. NEUNAM & SON, Easton, Md.</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE
<i>MAY 12 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Richard L. Jones</i> | |

Page 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

07532

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07524

| | | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Mattie Winthrop Williams</i> | | | 2a. DATE OF DEATH
5 Month 2 Day Year 69 <i>2:30</i> P M | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
March 5, 1880 | | 6. AGE (In years last birthday)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Talbot Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Easton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Memorial Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housework | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Easton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
108 N. Higgins | |
| 14. FATHER'S NAME First Middle Last
Peter Morris | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah Roach | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO | | | 16b. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT Address
Maurice W. Williams, Preston, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Congenital heart failure</i>
4123 DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Coronary heart disease</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 weeks
5 yrs. | | |
| | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct</i> , 19 <i>66</i> , to <i>May</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2 May</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Stephen P. Carney</i> | | | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
5-6-69 | | |
| 22d. PHYSICIAN'S NAME (Type)
Stephen P. Carney | | | | 22e. ADDRESS
Easton, Md. 21601 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
May 5, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Hill Crest Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Federalsburg, Caroline, Md. | | | | |
| 24. FUNERAL DIRECTOR
<i>Trampton Funeral Home</i> | | | | ADDRESS
Federalsburg Md | | 25a. REC'D BY REGISTRAR
MAY 8 1969 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jones</i> | | |

1994

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|-----------------------------------|------------------|--|
| 07533 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 07525 | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| Louis Clayton Willis | | | | | | 5 Month 23 Day 69 Year | | 9:45 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | | |
| M | | White | | Feb. 4, 1885 | | 84 YRS. | | MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| Maryland | | U. S. A. | | | | Talbot | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Easton | | | Memorial | | | Farmer (Retired) | | | Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Talbot | | Easton | | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | |
| Louis Clayton Willis | | | | | | Elizabeth Ann | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| No | | | 215-38-0176 | | W. Elizabeth B. Willis | | | Easton, Md. R.D. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) HEART FAILURE | | | | | | | | 36 HOURS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | 2 YEARS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| CHOLECYSTITIS CAROTID ARTERY STENOSIS | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | C. W. Bain MD | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| | | | | | | | | | | 5/24/69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | CRW BAIN | | 22e. ADDRESS | | 210 DOVER, EASTON, Md. | | | |
| | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| | | May 26, 1969 | | Spring Hill | | Easton | | Talbot | | Md | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Bain | | | | Easton Md | | MAY 26 1969 | | Charles Judge | | | |

0385

RECEIVED



MAY 28 1969

4000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|---|-------------------------------|------------------------------------|--|--|
| 07534 | | | | | CERTIFICATE OF DEATH | | | | | 07526 | | | | |
| 1. DECEASED-NAME
(Type or print) <i>John Wesley Wilson</i> | | | | | 2a. DATE OF DEATH
5 Month 13 Day Year 69 | | | | | 2b. HOUR
10:30 PM | | | | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>Negro</i> | | 5. DATE OF BIRTH
<i>12/12/19</i> | | | 6. AGE (In years last birthday)
<i>49</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>MD</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. - A</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Talbot</i> Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Easton</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Memorial</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD</i> | | | | 13b. COUNTY
<i>Talbot</i> | | 13c. CITY OR TOWN
<i>Easton</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| 14. FATHER'S NAME
First Middle Last
<i>John Wilson</i> | | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Leola Paul</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>YES</i> | | | 16b. SOCIAL SECURITY NO.
<i>WW# 11 214-12-6354</i> | | 17. INFORMANT
Address
<i>Sevenera Wilson</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4002</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>MALIGNANT Hypertension</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>4002</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>UNKNOWN</i> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/1/69</i> , 19__, to <i>5/13/69</i> , 19__, that (I) (we) last saw the deceased alive on <i>5/13/69</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Dorsett D. Smith</i> | | | | | | | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>5/14/69</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>DORSETT D. SMITH M.D.</i> | | | | | 22e. ADDRESS
<i>EASTON, MD. 21601</i> <i>5/14/69</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>5/17/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Unionville Cem</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>EASTON TA MD</i> | | | | | | |
| 24. FUNERAL DIRECTOR
<i>George H. Russell</i> | | | | | ADDRESS
<i>Easton MD</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAY 19 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |



Mr. Tolson
 Mr. E. A. Tamm
 Mr. Clegg
 Mr. Glavin
 Mr. Ladd
 Mr. Nichols
 Mr. Rosen
 Mr. Tracy
 Mr. Carson
 Mr. Egan
 Mr. Gurnea
 Mr. Hendon
 Mr. Pennington
 Mr. Quinn
 Mr. Nease
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